VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 4, 2020

Mr. Shawn Hallisey, Administrator
Barre Gardens Nursing And Rehab Llc
378 Prospect Street
Barre, VT 05641-5421

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 15, 2020**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING ______ B. WING ______	C 01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRE GARDENS NURSING AND REHAB LLC	378 PROSPECT STREET BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite facility reported incident investigation was conducted in conjunction with a complaint investigation by the Division of Licensing and Protection on 1/15/2020. There is a regulatory finding identified as a result of these investigations.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, and record review the facility failed to prevent abuse for one (1) of three (3) residents (Resident #1). Findings include: Per record review, a Nursing Incident Note dated 1/6/2020 at 9:30 PM states that "the LNA went to answer (Resident #1's) call light and noticed that the door to her/his room was closed. When the LNA opened the door, s/he saw Resident #2 in the room, standing over (Resident #1's) bed, in	F 600	How will the corrective action be accomplished for those residents found to have been affected by the alleged deficient practice? R2 is no longer a resident at the facility. R1 has been followed by social services and feels safe and secure in the facility and remains at baseline at this time. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents have the potential to be affected by this alleged deficient practice. These residents will be protected from abuse. A house-wide audit was conducted on residents that are currently exhibiting aggressive verbal or physical behaviors to ensure interventions have been implemented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Halliday
TITLE: Administrator
(X6) DATE: 2/3/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600 Continued From page 1

the dark. S/he had a blanket wrapped around (Resident #1's) head, face, and arms". Per a Social Service Note dated 1/7/2020, Resident #1 reported that Resident #2 came in and beat on her/him. A Nursing Note dated 1/13/20 at 10:21 PM states that Resident #1 stated "Do you know the [woman/man] who tried to kill me, he hit me in the back of my head and I stopped fighting back and then [s/he] stopped. Do you know [his/her] name?" The nurse sat with the resident for greater than 20 minutes while resident cried and again offered additional emotional support.

On 1/15/20 at 12:32 PM during an interview the Director of Nursing Services (DNS) confirmed that Resident #2 had a history of behaviors with staff. S/he had been on 15 minute checks since 12/19/19 due to behaviors in her/his room such as tearing down the curtains.

Per interview on 1/15/20 at 3:50 PM with the Licensed Practical Nurse (LPN), Resident #2 "had been on 15 minute checks due to aggressive behaviors. [S/he] was violent and aggressive to female staff. I was very afraid of [her/him], for staff, self, and residents". The LPN also stated that when s/he was giving Resident #2 her/his 8:00 PM medications that evening, Resident #2 said to her/him "My mother hates you and she must die". When the LPN entered Resident #1's room after the incident she noted her/him to be "very upset, crying, face very red, and visibly shaking" and that "[S/he] reported in [her/his] statement that [s/he] played dead to survive".

During an interview with an LNA on 1/15/20 at 4:11 PM, the LNA stated that "the next couple days [s/he] was scared and asked is [s/he]

F 600

What measures will be put in place to ensure that the alleged deficient practice will not occur?

All staff have been educated on the abuse policy to include identification of aggressive verbal or physical behaviors and implementing interventions.

How will the facility monitor its corrective action to ensure that the alleged deficient practice will not reoccur?

Random audits will be conducted of residents exhibiting aggressive verbal or physical behaviors to ensure interventions have been implemented. These audits will be completed weekly x4 and then monthly x2 or until substantial compliance has been achieved. The results of the audits will be brought to the QAPI committee meeting for further review.

F-600 POC accepted 2/3/20
S. Freeman, RN / S. Perry RN

completion date: — 2/7/20

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 2 coming home, is [s/he] coming back?". On 1/15/20 at 4:30 PM, during an interview with Resident #1 s/he stated "someone tried to kill me. [S/he] isn't here anymore. They told me [s/he] was never coming back, I hope that's true".	F 600		